Outcome Assessment Information Set (OASIS) Comprehensive Assessment Survey Process *

G310 §484.11 Condition:
Release of Patient Identifiable OASIS Information

Condition-level regulation
- No standards
- Termination is only option
- System of Records (SOR) published June 19, 1999
- Modified December 27, 2001
- SOR requires "Patient Privacy Notices"
- Establish "ownership" of data
- CMS national repository holds OASIS data
- HHA keeps OASIS data confidential as part of Conditions of Participation §484.11
  - Must protect confidentiality at HHA level
  - May use agent or contractor to encode and submit data
  - Chains may submit data to the State from the individual HHAs they own
  - Vendors can encode & transmit to State
  - Written agreement is required
  - Violations of confidentiality are the responsibility of the HHA
  - Internet use prohibited
- CMS keeps OASIS data confidential as part of Privacy Act of 1974
  - Privacy Act of 1974 governs CMS-owned data
  - Protects the confidentiality of patient data at Federal level
  - Data Use Agreement in effect for routine uses covered under the SOR
  - Covered:
    - CMS staff
    - CMS contractors
    - State survey staff
    - Regional Home Health Intermediaries (RHHI)
    - Quality Improvement Organizations (QIO)
- Patient Privacy Notices
  - One for Medicare/Medicaid patients
  - One for non-Medicare/non-Medicaid patients
  - CoP 484.10(a) Notice of rights—Tag G102
  - HIPAA Privacy Rule: http://www.cms.hhs.gov/HIPAAGenInfo/
- Patient Privacy Rights. The right to:
  - Be informed that OASIS information will be collected & the purpose of collection
  - Have the information kept confidential & secure
  - Be informed that OASIS information will not be disclosed except for legitimate purposes allowed by the Federal Privacy Act
  - Refuse to answer questions
  - See, review, & request changes on their assessments
- Patient Assessment Review Request
  - OASIS Privacy Act Statement provides the patient with the opportunity to see, review, copy or correct personal OASIS information currently in effect

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G320 §484.20 Condition:
Reporting OASIS Information

Electronically report all data collected per §484.55

G321 **Standard: Encoding OASIS data**
HHA must encode & transmit OASIS data within 30 days of assessment
- The HHA must encode & be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set
- New reporting regulation went into effect 6/21/06:
  - No 7-day lock-date requirement
  - Transmit within 30 days of assessment

G322 **Standard: Accuracy of encoded OASIS data**
- The encoded OASIS data must accurately reflect the patient's status at the time of assessment

Standard: Transmittal of OASIS data

G324 Transmit all completed assessments
- For all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section
- Effective 6/21/2006 words "completed in the previous month" have been removed

G325 Transmission of test data
- HHA applies to become a Medicare provider
- HHA must demonstrate ability to comply with all CoPs *before* certification
  - This includes OASIS transmission
- Test transmission must be done before initial survey
- HHA needs 2 sets of user IDs & passwords
- State issues temporary user ID & passwords for State and MDCN accounts
- HHA demonstrates it can collect, encode & transmit OASIS data before certification
- HHA needs successful validation report
- See SOM 2202.10
- Applicable to HHAs that:
  - Themselves transmit
  - Use a vendor to transmit
  - Use another HHA to transmit— "corporate office"
  - Seek initial certification via deemed status
- Exceptions
  - Patient categories:
    - Patients under 18
    - Maternity patients
    - Patients receiving only unskilled services
    - Private pay
  - Process
    - HHA attests intention to State
    - HHA contacts State if any changes

G326 Transmit data using electronics communications software that provides a direct telephone connection from the HHA to the State agency or CMS OASIS contractor.

G328 Transmit data that includes branch identification number
- MDCN: Private communications network that replaces telephone dial-up lines to the State
- HHAs will use MDCN as the link to the State

G327 **Standard: Data format**
Encode/transmit data using specified software
- The HHA must encode & transmit data using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specification, & data dictionary, and that includes the required OASIS data set

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G330 §484.55 Condition:
Comprehensive Assessment of Patients

- HHA performs a comprehensive assessment on all patients
- Assessment must:
  - Be patient-specific
  - Be accurate
  - Reflect current health status
  - Contain desired outcomes
  - Identify patient's need for home care
  - Meet the patient's medical, nursing, rehabilitative, social and discharge planning needs
  - Verify Medicare patient's eligibility, including homebound status
  - Incorporate current version of OASIS when applicable
- OASIS Web Based Training - http://www.oasistraining.org/oasis11/upfront/u1.asp

G331 **Standard: Initial assessment visit**
RN nurse must conduct an initial assessment visit
- RN determines patient's immediate care and support needs
- RN determines patient's eligibility for Medicare home health including homebound status

G332 Initial assessment
- Must be held:
  - Within 48 hours of referral or
  - Within 48 hours of patient's return home or
  - On physician ordered start of care date

G333 Initial assessment by rehabilitation therapy when that is the only service ordered and it establishes program eligibility
- Therapist may perform when therapy is the only service ordered, and the need for that service establishes program eligibility
- Qualified to complete start of care (SOC) assessment:
  - For nursing-only cases—RN
  - For therapy-only cases—RN or Therapist
  - For *mixed* cases—RN

G334 **Standard: Completion of the comprehensive assessment**
Comprehensive assessment requires completion:
- In a timely manner
- Consistent with patient's immediate needs
- No later than 5 calendar days after the start of care

G335 RN must conduct a complete assessment and for Medicare patients determine eligibility & homebound status

G336 PT/ST/OT may complete comprehensive assessment if only service ordered. The OT may complete if OT establishes eligibility.
- Qualified to complete SOC assessment:
  - For nursing-only cases—RN
  - For therapy-only cases—RN or Therapist
  - For mixed cases—RN
- If OT establishes program eligibility, OT can perform SOC assessment (not Medicare)

G337 **Standard: Drug regimen review**
Comprehensive assessment must include review of all meds the patient is currently taking
- Must review all current medications
- Identify any potential adverse effects/drug reactions
  - A *working* definition would include any undesirable or unexpected event that requires discontinuing a drug, modifying a dose, prolonging hospitalization, or administering supportive treatment
- Ineffective drug therapy
  - Inappropriate drug
  - Inadequate:
    - Dose
    - Duration
    - Frequency
    - Monitoring
- Significant side effects
  - A consequence other than the one for which the drug is being used:
    - Drowsiness
    - Nausea
    - Diarrhea
    - Dizziness
- Significant drug interactions
  - When administration of, or exposure to, a substance modifies a patient's response to a drug:
  - Decreased therapeutic effect
  - Increased therapeutic effect
- Duplicate drug therapy
  - Same drug prescribed or
  - Same class of drug prescribed
  - Often the result of multiple prescribers
- Noncompliance with drug therapy
  - Results in less than optimal therapeutic response
  - Due to:
    - Limited financial resources
    - Limited access to transportation
    - Lack of perceived need for the medication

G338 **Standard: Update of the comprehensive assessment**
Comprehensive assessment must be:
- Updated and revised (including OASIS) as frequently as needed
- Updated when patient has major decline or improvement in health status

G339 Follow-up assessment conducted within last 5 days of every 60 days, beginning with start of care date, transfer, change in condition, or discharge and return during 60-day episode
- No less frequently than last 5 days of every 60 days, beginning with the SOC date, unless one of the following occurs:
  - Beneficiary elected transfer
  - Significant change in condition (SCIC) with new case-mix
  - Discharge and return to same HHA during the 60-day episode

G340 Assessment must be updated within 48 hours of the patient's return to the home from hospital admission of 24 hours or more for any reason other than diagnostic tests

G341 Discharge/transfer assessments
- Assessment updated at discharge
- Data items must be collected at inpatient facility admission (Hospital, SNF/NF, or Rehab facility)
- Discharge

G342 **Standard: Incorporation of OASIS data items**
OASIS data items must be incorporated into HHA's own assessment (for applicable patients)
- Incorporation must include:
  - Clinical record items
  - Demographics/Patient history
  - Living arrangements/Supportive assistance
  - Sensory status
  - Integumentary
  - Respiratory status/ Elimination status
  - Neuro/emotional/behavioral status
  - Activities of daily living (ADLs)
  - Medications
  - Equipment management
  - Emergent care
- OASIS applies to all Medicare and Medicaid patients who are receiving *skilled* services from the HHA
  - *Note:* Medicare Modernization Act of 2003 temporarily suspended OASIS requirement for collection of data on non-Medicare and non-Medicaid patients
- OASIS application:
  - HHA must still collect and transmit OASIS information on:
    - Medicare (Traditional fee-for-service)
    - Medicare (HMO/managed care)
    - Medicaid (Traditional fee-for-service)
    - Medicaid (HMO/managed care)
  - HHA must still conduct a comprehensive assessment at the time points in 42 CFR 484.55 including:
    - Initial assessment
    - Start of care/resumption of care
    - Follow up
    - Discharge/transfer
    - Drug regimen review
  - Exceptions:
    - Pediatric patients (under 18)
    - Maternity patients
    - Patients receiving only homemaker or chore services
    - Patients receiving personal care only (unskilled or aide-only cases)
    - Non-Medicare and non-Medicaid patients